No. 88-2043

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

GERALD L. BALILES, *et al.*,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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BRIEF OF THE NATIONAL GOVERNORS' ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, COUNCIL OF STATE GOVERNMENTS, U.S. CONFERENCE OF MAYORS, INTERNATIONAL CITY MANAGEMENT ASSOCIATION, NATIONAL CONFERENCE OF STATE LEGISLATURES, AND NATIONAL LEAGUE OF CITIES AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the Medicaid statute confers on health care providers a substantive federal right enforceable through 42 U.S.C. § 1983 to challenge a State's reimbursement plan in federal court.

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INTEREST OF THE *AMICI CURIAE*

The *amici* are organizations whose members include state, county, and municipal governments and officials throughout the United States. *Amici* and their members have a compelling interest in legal issues that affect state and local governments.

This case is of importance to *amici* because it is another example of the proliferation of actions filed under 42 U.S.C. § 1983 against States and their political subdivisions to vindicate alleged federal rights arising from

federal grant programs. Such litigation disrupts the federal-state relationship under these programs and undermines the States' functions and prerogatives.

This case attacks Virginia's plan for administering its Medicaid program. Medicaid, a cooperative federal-state program that provides funds for medical services for the needy, leaves to each State the determination of eligibility requirements and reimbursement rates for patients and health care providers. The federal law and regulations evidence two concerns: to provide adequate health care to Medicaid recipients and to contain costs.

State plans are subject to review and approval by the United States Department of Health and Human Services ("HHS"). Virginia's plan has been approved. Nonetheless, respondent asserts that Virginia's plan violates its members' rights under the federal Constitution, laws, and regulations. Respondent's specific claim is that Virginia's plan yields reimbursement rates that do not conform to the requirements of the Medicaid Act in that they do not reasonably and adequately meet the costs of efficiently operated hospitals. But respondent can point to no specific violations of the detailed federal law and regulations or of the Constitution.

Federal law requires each State to administer its plan through a special state agency and to establish administrative hearing processes to resolve disputes. The ruling below permits respondent to bypass those procedures in order to assert in federal court purported rights that exist only by virtue of state law. The decision permits, indeed requires, a federal court to define, in the first instance, a right that is a creature of state law. Moreover, it turns every dispute arising out of the State's administration of a federal-state cooperative program into a federal case. It exposes States and their political subdivisions to heavy potential financial liability, which Congress itself chose not to impose. Finally, it denigrates the state administrative procedures mandated by Congress

by making the federal courts the initial claims agency for all dissatisfied Medicaid health care recipients and providers. Thus, the decision below, in both its substantive and procedural aspects, poses a threat to the independence and integrity of the sovereign States in our federal system.

Amici submit that the decision below is wrong. Because this Court's decision will have a direct effect on matters of prime importance to *amici* and their members, *amici* submit this brief to assist the Court in its resolution of the case.[1]

STATEMENT

Respondent Virginia Hospital Association ("VHA") is a nonprofit organization whose members are public or private Virginia health care providers. A portion of each member's revenues is derived from its participation in the Medicaid Assistance Program, 42 U.S.C. § 1396 *et seq.* ("Medicaid program"), administered by petitioner Commonwealth of Virginia, Department of Medical Assistance Services ("DMAS").[2] VHA believes that its members are entitled to more money from DMAS.

Virginia, like every State, has citizens who cannot afford adequate health care. In order to assist these needy persons, Virginia chooses to participate in the Medicaid program, a federal-state partnership designed to provide health care services to the poor. See *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985). Under Medicaid, the federal government provides the bulk of the funding of medical care for the needy, while the States actually develop, administer, and implement the program in accordance with their own state Medicaid plans, which must be approved by the Secretary of HHS. *Ibid.* If

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[1] The parties' letters of consent, pursuant to Rule 36 of the Rules of this Court, have been filed with the Clerk of the Court.

[2] Petitioners are officials of the Commonwealth of Virginia: Gerald Baliles, the Governor; Eva S. Teig, Secretary of Human Resources; and twelve members of the Board of DMAS.

the terms or administration of the state plan do not conform to federal standards, the Secretary of HHS is authorized to withhold all or part of the federal funding. 42 U.S.C. § 1396c. The Medicaid statute requires participating States to "provide for procedures of prepayment and postpayment claims review." 42 U.S.C. § 1396a (a) (37) (B).

Virginia's Medicaid plan ("Virginia plan") has both a substantive and a procedural component. The substantive component consists of the methodology whereby DMAS sets prospective *per diem* rates for inpatient care of Medicaid patients (the "reimbursement system"). In brief, the reimbursement system establishes seven categories of hospitals ("peer groups") based on geographical location (urban/rural) and size (number of beds per hospital). For each peer group, a baseline for reimbursement rates is calculated using cost medians per patient day derived from 1981 hospital cost reports. Further rate adjustments are made for urban peer groups to allow for wage variations between metropolitan areas. Wage differentials are based upon labor costs in the Standard Metropolitan Statistical Areas as developed by the federal Office of Management and Budget. Once each peer group's median cost per day is thus established, that amount functions as a quarterly ceiling on reimbursement rates within that peer group, as increased periodically through the use of an inflation index. Effective July 1, 1982, the reimbursement system was approved by the Health Care Financing Administration ("HFCA"), the agency of HHS with the responsibility to ensure the compliance of state reimbursement systems with the Medicaid Act and its implementing regulations. In *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), an action brought by a member hospital of VHA, the district court upheld the legality of the reimbursement system in its entirety.[3]

[3] Subsequent changes made to the reimbursement system are not relevant to this litigation. They include, for example, changes in audit procedures and scope of Medicaid coverage.

The procedural component of Virginia's plan consists of regulations prescribing procedures for the filing and processing of appeals by health care providers not satisfied with their prospective rates (the "appeals system"). Under the appeals system, rate reimbursement disputes are resolved by a three-level administrative review process (informal conference, formal hearing, and agency head decision). Va. Code Ann. 9-6.14:11 *et seq.* (1989). At each stage, administrators are guided by comprehensive regulations. A provider is entitled at each stage to introduce a wide variety of evidence demonstrating that it operates under unique conditions not shared by other members of its peer group and that it is economically and efficiently operated. See generally *State Plan Under Title XIX of the Social Security Act*, Exhibit 1 of Respondent's Amended Complaint, J.A. 24-45. A provider dissatisfied with the administrative decision may appeal to the Virginia circuit courts and to the Virginia Court of Appeals. Thereafter, appeal to the Virginia Supreme Court is available by writ. Va. Code Ann. § 9-6.14:16 *et seq.* (1989). This appeals system was approved by the HCFA in March 1986 and was upheld by the local federal district court.

Respondent, failing to avail itself of this congressionally mandated (42 U.S.C. § 1396a(a)(37)(B)) appeals process, filed this federal court suit under, *inter alia*, 42 U.S.C. § 1983, seeking declaratory and injunctive relief. Respondent alleged, *inter alia*, that the reimbursement rates established under Virginia's reimbursement system do not conform to the requirements of the Medicaid Act in that they do not reasonably and adequately meet the costs of efficiently and economically operated hospitals. Amended Complaint ¶¶ 1, 17, J.A. 3-4, 13. Determining that respondent was in privity with the plaintiff in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), the district court dismissed the complaint on grounds of collateral estoppel. The Fourth Circuit reversed and remanded. *Virginia Hospital Ass'n v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

On remand, Virginia moved to dismiss the complaint on eight jurisdictional grounds. The district court denied the motion and certified the eight issues to the Fourth Circuit for interlocutory appeal. The court of appeals affirmed, holding, in part, that the respondent's complaint stated a cause of action under 42 U.S.C. § 1983. Relying on *Maine v. Thiboutot*, 448 U.S. 1 (1980), and *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981) (*"Pennhurst I"*), the court of appeals held that: (1) the language and legislative history of 42 U.S.C. § 1396a(a)(13)(A) of the Medicaid Act reveal a congressional intent both to allow providers a private right of action against States for their failure to comply with the Medicaid Act[4] and to ensure providers reimbursement rates that are reasonable and adequate in fact, and (2) the enforcement mechanisms, including congressionally mandated state administrative appeals and remedies, are not so elaborate as to reveal a congressional intent to foreclose private judicial redress against a State through a Section 1983 proceeding. Pet. App. A-5 to A-12.

SUMMARY OF ARGUMENT

Title 42 U.S.C. § 1983 provides a remedy for the deprivation of a right, privilege, or immunity secured by the Constitution or by federal law, and only when Congress has not indicated an intent to foreclose such a remedy.

Medicaid is a federal-state cooperative endeavor to provide medical services for the needy. Federal law establishes no entitlement to any particular level of patient care reimbursement. It permits each participating State to develop its own plan and reimbursement rates. Amendments to the original Medicaid Act have granted the States progressively wider discretion in determining and applying their rate-setting methodology.

[4] The court appears to have been confused about what issue it was deciding. At one point it framed the issue as "whether the Medicaid Act provides VHA with any substantive right." Pet. App. A-5. Elsewhere the court framed the issue as "analyzing a claim of an implied right of action." *Id.* at A-10 n.7. These are two distinct issues. The threshold inquiry is whether the statute confers a substantive right. If it does, then the issue is whether there is a private cause of action under the statute or Section 1983 to enforce that right. See *Pennhurst I*, 451 U.S. at 28 n.21 (citing *Southeastern Community College v. Davis*, 442 U.S. 397, 404 n.5 (1979)).

Respondent's assertion of a federal right to "reasonable and adequate" reimbursement under the Medicaid statute finds no support in the language, legislative history, or relevant agency interpretation of this law. The statute does not explicitly confer nor does it imply such a right. The statute requires only that a state plan provide for reimbursement that is reasonable and adequate as determined by the methods and standards adopted by each State and approved by the Secretary of HHS. By focusing on the state plans, the statute establishes a structure of federal-state relations rather than conferring individual rights.

The decision below rested primarily on the grounds that the purpose of the Medicaid Act is to provide reasonable and adequate reimbursement rates and that respondent was among the intended beneficiaries of the program. But the Medicaid Act does not contain the type of language from which rights can be inferred. Further, decisions of this Court have made clear that an intended benefit is not sufficient to create an enforceable right. Finally, providers like members of VHA are not the holders of any "right" that the Medicaid Act might confer.

Even if respondent has a right to "reasonable and adequate" reimbursement, state law so thoroughly gives meaning and effect to this general standard that this right cannot reasonably be said to be a federal right secured by federal law. State law rights or rights secured by state law are not enforceable under Section 1983.

In any event, whatever right respondent may derive from the Medicaid law, the comprehensive remedies mandated by that statute indicate that Congress intended to

foreclose its enforcement under Section 1983. Primary among these remedies are the congressionally mandated state appeals systems. Virginia's appeals procedures are designed to, and in practice do, secure whatever rights are granted by its reimbursement system. Federal oversight mechanisms compliment Virginia's appeals system in securing these rights. These remedies are sufficient to secure whatever rights are granted by the Medicaid program and Virginia's voluntary participation in it. Moreover, allowing respondent to engraft a Section 1983 remedy onto the Medicaid Act would seriously impair the effectiveness of Virginia's reimbursement and appeals systems.

Respondent's argument that the "reasonable and adequate" reimbursement standard in the Medicaid statute is independent of Virginia's plan would, if successful, require this Court to rewrite the Medicaid statute and thereby nullify the carefully crafted scheme for state administration of the Medicaid program in accordance with state plans. This course would have profoundly adverse consequences for federal-state relations and would swamp the federal courts with similar suits.

ARGUMENT

THE MEDICAID STATUTE GIVES RESPONDENT NO SUBSTANTIVE FEDERAL RIGHT TO REASONABLE AND ADEQUATE REIMBURSEMENT ENFORCEABLE UNDER 42 U.S.C. § 1983.

A cognizable claim under 42 U.S.C. § 1983 has three distinct predicates. The claim must (1) arise out of the deprivation of an enforceable *right* (see *Pennhurst I*, 451 U.S. at 22 & n.16), (2) that is secured by *federal* law (see *Martinez v. California*, 444 U.S. 277, 285 (1980)), (3) for which Congress has not provided a comprehensive remedy (see *Middlesex County Sewerage Authority v. National Sea Clammers Ass'n*, 453 U.S. 1, 20-21 (1981) ("*Sea Clammers*")). Because respondent has not satisfied even one of these requirements, its action is not cognizable under Section 1983.

A. Respondent's Allegations Do Not Establish A Violation Of A Federal Right Enforceable Under Section 1983.

Respondent alleges that the *per diem* reimbursement rates established by the methods and standards of Virginia's Medicaid plan violate the Medicaid Act and regulations in that they "have not reasonably nor adequately met the costs incurred by economically and efficiently operated hospitals." Amended Complaint ¶ 17, J.A. 13; see also ¶¶ 1, 35, 39, J.A. 3-4, 20, 21. By grounding its cause of action in 42 U.S.C. § 1983,[5] respondent apparently believes that DMAS' refusal to pay VHA members at a higher rate constitutes a violation of a right secured to the VHA by federal law. But nowhere does respondent identify any right that has been violated or how DMAS' refusal to pay VHA members at a higher rate constitutes a violation of this unidentified right. Respondent apparently seeks to assert a right to "reasonable and adequate" reimbursement under 42 U.S.C. § 1396a (a) (13) (A), commonly known as the Boren Amendment to the Medicaid Act. But this purported right does not have a basis in the plain language of the statute itself, its legislative history (particularly the trend toward state discretion), or the interpretation of the relevant federal agency. Respondent's interest in "reasonable and adequate" reimbursement does not rise to the level of an enforceable federal right.

The Boren Amendment provides that:

> [a] *State plan* for medical assistance must . . . provide . . . for payment . . . of . . . services provided under the plan through the use of rates (*determined in accordance with methods and standards developed by the State . . .*) *which the State finds*, and makes assurances satisfactory to the Secretary, *are reasonable and adequate* to meet the costs which must be

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[5] See Amended Complaint, ¶¶ 2, 35, 37, 39, J.A. 4, 20, 21.

> incurred by efficiently and economically operated facilities . . . .

42 U.S.C. § 1396a(a)(13)(A) (emphasis added). This language does not itself expressly confer on providers a right to reasonable and adequate reimbursement. This congressional silence is significant. Had Congress intended to create such a right, it surely knew how to do so. See *Pennhurst I*, 451 U.S. at 17-18, 27, citing *King v. Smith*, 392 U.S. 309, 333 (1968), and *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). See also *Rose v. Rose*, 481 U.S. 619, 628 (1987). The usual way for Congress to confer such a right is through the explicit use in the statute of "right- or duty-creating language" that benefits a specific class of persons. *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979). There is no such language in the Amendment or anywhere else in the Medicaid Act. In fact, the Amendment speaks only of a state Medicaid plan, and not of actual reimbursement rates for providers. The Amendment does not require any specific plan, but only that the State, if it wishes to participate in Medicaid have a plan that is approved by the Secretary of HHS. The focus is on the state system and not on providers.[6] Cf. *Pennhurst I*, 451 U.S. at 22 (rather than conferring individual rights, Developmentally Disabled Assistance and Bill of Rights Act has "systemic focus"). The fact that Congress chose not to use explicit language of rights and duties in the Boren Amendment strongly suggests that it did not intend to create such rights and duties through this Amendment.

The court of appeals recognized that the Boren Amendment does not expressly confer any rights on providers (Pet. App. A-5), but found in the Amendment an implied substantive right on behalf of health care providers to reasonable and adequate reimbursement rates. Its analysis began with its view that the "express purpose" of this statute "is to require reimbursement rates that are 'reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated [providers] . . . and to assure that [Medicaid patients] have reasonable access . . . to inpatient hospital services of adequate quality.'" Pet. App. A-7, citing 42 U.S.C. § 1396a(a)(13)(A) (ellipses and brackets in original). This interpretation exhibits a fundamental misunderstanding of the structure of federal-state relations established by the Medicaid Act in general and the Boren Amendment in particular.

[6] Moreover, as this Court made clear in *Pennhurst I*, even the use of explicit language of rights and duties is not dispositive as to Congress's intent to confer rights. Congress's use of such explicit language may simply be its way of "encouraging a specific type of treatment" rather than "mandating it." *Pennhurst I*, 451 U.S. at 27.

Medicaid is a federal-state "cooperative endeavor." *Harris v. McRae*, 448 U.S. 297, 308 (1980). The federal government approves plans submitted by each State for funding medical services to the poor and subsidizes a significant portion of the costs incurred by the States, but each State administers the program in conformity with its own plan. See *Alexander v. Choate*, 469 U.S. at 289 n.1.

Originally, the States had no choice in administering Medicare but to reimburse health care facilities according to the cost methodology used by the federal government. But in 1972, concerned about escalating costs, Congress adopted the "reasonable cost related standard" for reimbursement, thereby allowing States to make their own reimbursement decisions and giving them flexibility in achieving satisfactory payment arrangements with health care facilities. H.R. Rep. No. 231, 92d Cong., 1st Sess. 101 (1971).[7] In 1980, Congress was again concerned

[7] As the court observed in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980):

> Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that

about the inflationary effect of the Medicaid reimbursement standard. Accordingly, by the Boren Amendment, Congress instituted the current reimbursement standard, which requires reasonable and adequate rates as determined by methods and standards developed by the State.

Through the Boren Amendment Congress expanded, yet again, the States' discretion in developing and implementing reimbursement methodologies.[8] Its plain language expresses Congress's clear intent that reimbursement rates are to be determined in accordance with state, not federal, methods and standards. The executive branch, through HCFA,[9] has acknowledged the "legislatively mandated flexibility" that the statute grants to the States in determining reimbursement rates. 48 Fed. Reg. 56049 (1983). Accordingly, HCFA has specifically declined to issue more "explicit criteria for Federal review of States' methods and standards for establishing payment rates" lest "such a list of criteria . . . be viewed as imposing Federal standards for payment rates, an effect that would

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would be simpler and less expensive than the complex Medicare reasonable cost formula. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972). . . . Additionally, Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.

[8] The legislative history behind the 1981 amendment extending the Boren Amendment to hospitals as well as other long-term care facilities indicates that

> [i]n eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981).

[9] HCFA, an agency of HHS, must approve reimbursement rates set by state Medicaid plans. Its opinion is entitled to deference. *Wright v. Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 430 (1987); *Schweiker v. Hogan*, 457 U.S. 569, 588 (1982); *Blum v. Bacon*, 457 U.S. 132, 141 (1982).

be contrary to the legislative intent." 48 Fed. Reg. 56050 (1983). In short, Congress's purpose in enacting the 1972 "reasonable cost related standard" and the Boren Amendment was to control costs by departing from a federal reimbursement standard and allowing the States to adopt their own standards.

Once the court of appeals improperly inferred the "express" purpose of the Boren Amendment, it concluded that the Amendment "reveals an unambiguous intent to assure reimbursement rates that are reasonable and adequate in fact." Pet. App. A-7. Assuming, *arguendo*, that this conclusion is correct,[10] it still does not follow that the Boren Amendment creates a substantive right to such a level of reimbursement.

This crucial and dispositive point merits extended discussion. This Court has held that federal statutes imply substantive rights that can be enforced through Section 1983 when the statute contains unambiguous and specific language that effectively imposes binding obligations on the States. *Pennhurst I*, 451 U.S. at 17, 24-27. Federal statutes imply substantive rights through "specific language of obligation [that] narrowly cabins the discretion of officials" (*Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987)), or through "language [that]

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[10] There is good reason to believe that this conclusion is wrong. Most important, it assumes that there is an objective standard ("in fact") by which to judge what rates are reasonable and adequate. But "reasonableness" and "adequacy" are relative to what other providers are spending. Congress found that when it operated on the assumption of objectively reasonable rates prior to the enactment of the Boren Amendment, its cost reimbursement system was inherently inflationary. See nn. 7 & 8, *supra*. That is, the prior "reasonable" cost standard gave providers collectively an incentive to spend more so as to raise the rate of "reasonable" reimbursement. Respondent is asking this Court to read out of the Boren Amendment the mechanism that Congress explicitly adopted to minimize this inflationary effect, namely, the state plans. In our view, this request should be directed to Congress, not to the courts.

is unequivocally specific and mandatory." *Samuels v. District of Columbia*, 770 F.2d 184, 197 (D.C. Cir. 1985). See also *Alexander v. Choate*, 469 U.S. at 307-08 n.32. The Medicaid Act contains no specific obligation-imposing language that would give substance to the "right" to "reasonable and adequate" reimbursement. Thus there is no basis for inferring such a right from the Medicaid Act or its implementing regulations. See, *e.g.*, 42 C.F.R. §§ 447.250-447.253 (1988) (repeating the general language of the Boren Amendment).[11] Especially significant in this regard is the Act's express statement of its purpose as that "of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families . . . or disabled individuals . . . and . . . to help such families and individuals." 42 U.S.C. § 1396; see also *Schweiker v. Hogan*, 457 U.S. 569, 571 (1982). This is not the sort of language from which substantive rights can be inferred. Congress framed the statute in terms of "enabling" the States to aid the needy, rather than "obligating" them to do so.

This statement of purpose also serves to make clear that Congress intended the Medicaid program to benefit certain individuals. But simply because Congress intends to benefit a class of persons through a statute does not mean it intends to create for them a right to the benefit conferred. See *Bowen v. Gilliard*, 483 U.S. 587, 604-09 (1987); *Heckler v. Turner*, 470 U.S. 184, 189-90 & n.3 (1985).

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[11] The generality and vagueness of the "reasonable and adequate" standard of the Boren Amendment and its implementing regulations distinguish the present case from *Wright v. Roanoke Redevelopment*. In *Wright*, the Court found that the Brooke Amendment "could not be clearer" in imposing a specific "mandatory limitation" on rent charges. 479 U.S. at 430. On the basis of this specific language the Court concluded that "[t]he intent to benefit tenants is undeniable." *Ibid.* No such specific language is to be found in the present case, and hence there is no basis from which to infer an intent to confer rights on providers.

Pennhurst I illustrates this distinction. *Pennhurst I* dealt with the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.*, which the Court recognized was intended to benefit the developmentally disabled. See *Pennhurst I*, 451 U.S. at 11. Yet the Court, with specific reference to Medicaid, the very statute involved in this case, stated:

> In sum, nothing suggests that Congress intended the Act to be something other than a typical funding statute. Far from requiring the States to fund newly declared individual rights, the Act has a systematic focus, seeking to improve care to individuals by encouraging better state planning, coordination, and demonstration projects. Much like the Medicaid statute . . . the Act at issue here "was designed as a cooperative program of shared responsibilit[ies], not as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund."

Id. at 22 (quoting *Harris v. McRae*, 448 U.S. at 309).

Similarly, in *Alexander v. Choate*, the Court rejected the contention by a class of handicapped persons that Tennessee's Medicaid plan, which imposed a limit of fourteen days of inpatient hospital care per year, constituted discrimination under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Writing for a unanimous Court, Justice Marshall explained (469 U.S. at 302-03):

> Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not "adequate health care."

> The federal Medicaid Act makes this point clear. The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in "the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

Moreover, even if the Medicaid Act could be construed to create a substantive right, the holders of this right are not health care providers like the members of the VHA, but rather are Medicaid recipients, *i.e.*, patients of the VHA's members. The purpose of the Act is "to furnish . . . medical assistance on behalf of families . . . or disabled individuals . . . and . . . to help such families and individuals." 42 U.S.C. § 1396. This statutory language is conspicuous in its failure to mention the interests of providers at all. Medicaid was created to aid participating States in "the funding of medical services for the needy" (*Alexander v. Choate*, 469 U.S. at 289 n.1), not for providers.[12]

In sum, there is no support in any of the sources of statutory interpretation for respondent's claim that the Boren Amendment establishes reasonable and adequate rates *simpliciter* as the Medicaid reimbursement standard. Rather, the plain language of the Amendment provides that the standard for reimbursement is rates that the State finds are reasonable and adequate according to methods and standards developed by the State and ac-

[12] As the Second Circuit has observed: "That a particular nursing facility cannot survive without Medicaid participation was certainly not Congress' foremost consideration in its creation of the Medicaid program. . . . The benefits to a nursing home from its participation in Medicaid reimbursement results from nothing more than a statutory business relationship." *Case v. Weinberger*, 523 F.2d 602, 607 (2d Cir. 1975) (footnote omitted). See *Schweiker v. Hogan*, 457 U.S. 569 (1982) (health care recipient may bring an action under the Medicaid Act); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir.), cert. denied, 454 U.S. 832 (1981); *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979); see also *Silver v. Baggiano*, 804 F.2d 1211, 1216 n.3 (11th Cir. 1986).

cepted by the Secretary. See also 42 C.F.R. § 447.253 (1988) (state Medicaid agencies are only required to "make . . . findings" that their rates are "reasonable and adequate"). If this standard gives content to a right, it is no more than the right to an approved state plan providing for methods and standards by which the State determines what rates are reasonable and adequate reimbursement to health care providers generally. Moreover, assuming that a State chooses to participate in the Medicaid program, this "right" is violated only if either (1) the State does not have a plan, (2) the rates set are not in accord with the methods and standards in the plan, or (3) the methods and standards in the plan have not been accepted by the Secretary. None of these circumstances exists in the present case, and respondent does not allege that any does.

B. Assuming *Arguendo* That Respondent Has A Substantive Right To Reasonable And Adequate Rates Under the Medicaid Act, It Is Not A Right Secured By Federal Law.

Section 1983 affords relief only to a plaintiff deprived of a right, privilege, or immunity secured by the Constitution or federal law. See *Martinez v. California*, 444 U.S. at 285. That predicate is lacking in this case.

Even assuming that respondent has a right to "reasonable and adequate" reimbursement under the Boren Amendment, it is not a federal right in any meaningful sense. The state plans so thoroughly give meaning and effect to this "amorphous objective" [13] of "reasonable and adequate" reimbursement rates that the "right" to such a rate is a federal right only in the most formalistic sense, namely, that these words appear in a federal statute. Rather, the Medicaid Act, specifically, the Boren Amendment, and its regulations are designed so that the States are to provide whatever specific obligation-imposing and

[13] *Alexander v. Choate*, 469 U.S. at 303 (using this phrase to describe "adequate health care").

discretion-limiting language they think appropriate (subject to the Secretary's approval) in their state plans. If there are specific substantive rights and duties as to reimbursement rates, they are created by the state plans. If such rights exist, then, they are state rights, not federal rights. See *Oberlander v. Perales*, 740 F.2d 116, 119 (2d Cir. 1984) ("there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law"). As we discuss below, consistent with their status as state rights, the primary mechanisms for enforcing these rights are the state appeals systems. Thus these rights are not only state rights, but they are "secured by" state law, not federal law. And violations of state rights or rights "secured by" state law do not of themselves give rise to Section 1983 actions. See *Paul v. Davis*, 424 U.S. 693, 694, 699-702 (1976).

C. The Federal And State Remedies Provided For By The Medicaid Statute Are Sufficiently Comprehensive to Foreclose Private Actions Under Section 1983.

This Court has held that "[w]hen the remedial devices provided in a particular Act are sufficiently comprehensive, they may suffice to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Sea Clammers*, 453 U.S. at 20. The general rule to be derived from this Court's applications of the *Sea Clammers* test is that a remedial scheme is sufficiently comprehensive if it contains all of those remedial procedures that are jointly necessary and sufficient to secure the substantive rights conferred by the statute.[14] As a corollary to this rule, if the Section 1983 remedy impairs the effectiveness of

[14] See Note, *Comprehensive Remedies and Statutory Section 1983 Actions: Context as a Guide to Procedural Fairness*, 67 Tex. L. Rev. 627, 636 (1989) ("The Court's decisions indicate . . . that a section 1983 remedy is permissible only when the substantive statute fails to provide procedural remedies necessary to accomplish the underlying congressional purposes [of the statute].").

the Medicaid Act's reimbursement or appeals systems in securing the substantive rights conferred by the Act, then Section 1983 ought not to be used to enforce these substantive rights. See *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418, 423 (1987) (reading *Smith v. Robinson*, 468 U.S. 992, 1012 (1984), to hold that allowing a plaintiff to circumvent the Education of the Handicapped Act's administrative remedies would be inconsistent with Congress's carefully tailored scheme, which itself allowed private parties to seek remedies for violating federal law); see also *Great American Federal Savings & Loan Ass'n v. Novotny*, 442 U.S. 366, 378 (1979) ("Unimpaired effectiveness can be given to the plan put together by Congress in Title VII only by holding that deprivation of a right created by Title VII cannot be the basis for a cause of action under § 1985(3).").

The analysis must begin by defining the "right" to be protected by the remedies under examination. As we demonstrated in Part B, *supra*, any right to reasonable and adequate reimbursement rates conferred by the Boren Amendment is a state right, not a federal right. The remedial devices that Congress has mandated under the Medicaid Act reinforce this proposition. Consistent with the limited scope of these "rights" and their grounding in state law, the primary remedial devices under the Medicaid Act are the congressionally mandated state appeals systems. Congress intentionally left the enforcement of the state rights created by the state plans to the state appeals systems. In doing so, Congress manifested its intent to foreclose a Section 1983 remedy.

In enacting the Boren Amendment, Congress had two closely related goals: "[first,] to contain the spiraling costs of inpatient hospital services and [second,] to reduce potentially stifling and expensive federal oversight of state methodologies." *West Virginia University Hospitals v. Casey*, 885 F.2d 11, 23 (3d Cir. 1989). Congress implemented these goals by establishing the state

plans as linchpins of the Medicaid program,[15] and directing the Secretary of HHS to "keep regulatory and other requirements to that minimum necessary to assure proper accountability." S. Rep. No. 471, 96th Cong., 1st Sess. 28, 29 (1979). For example, Congress intended that a State's assurances made to the Secretary will be satisfactory unless by a formal finding the Secretary finds to the contrary. *Ibid.*; see also 42 C.F.R. § 447.256(b) (1988).[16] It is difficult to imagine that in reducing the

[15] The central role intended for state Medicaid plans is evidenced by the statute's framework. The detailed requirements found throughout the statute are all phrased in terms of what a state plan must provide. See 42 U.S.C. § 1396 *et seq.*; see also *Alexander v. Choate*, 469 U.S. at 289 n.1.

[16] Although reduced, federal oversight of state Medicaid plans is still significant. Once approved, the plan is subject to continued scrutiny by the Secretary of HHS to ensure that federal requirements are satisfied. *Charleston Memorial Hosp. v. Conrad*, 693 F.2d 324, 327 (4th Cir. 1982). The Department of HHS, through its Audit Agency, conducts audits annually or as appropriate of the state Medicaid agency's operations. 45 C.F.R. § 201.12 (1988). The Social and Rehabilitation Service of HHS is authorized to conduct a review to ensure that the State is complying with federal administrative requirements. 45 C.F.R. § 201.10 (1988). State Medicaid agencies must, under 42 C.F.R. §§ 431.17, 431.18(f) (1988), maintain records and make program policy materials available to providers who wish them. 48 Fed. Reg. 56051 (1983). If the Secretary of HHS determines that the State is improperly implementing its plan or not following a new federal requirement, he may either completely cut off federal funding (42 U.S.C. § 1396c; 45 C.F.R. § 201.6 (1988)) or "in his discretion" limit payments to "categories under or parts of the state plan not affected by such failure." 42 U.S.C. § 1396c. Finally, whenever a state Medicaid agency makes a change in its reimbursement methods and standards, and in any event at least once annually, the agency must make assurances to HCFA that it has found that its reimbursement rates are reasonable and adequate and that these rates ensure that recipients have reasonable access to providers. 42 C.F.R. § 447.253(a)-(c) (1988); 45 C.F.R. § 201.3 (1988). If this oversight was intended to secure any right, it is at best the "right" of providers to an approved state plan that provides for methods and standards by which the State determines what reimbursement rates are reasonable and adequate. See Part A, *supra*.

role of the federal government and in expanding the role of the States in the Medicaid program, Congress intended to allow private litigants to use Section 1983 in the federal courts to expand again the role of the federal government in the program.

Consistent with the key role played by the state plans in the Medicaid program, Congress intended that the primary remedial measures under Medicaid be at the state level. Each State is required by the Medicaid Act and regulations to provide an appeals system in which prepayment and postpayment claims are reviewed. 42 U.S.C. § 1396a(a)(37)(B). A State must provide written assurances that this "essential" element of its reimbursement plan is met. 48 Fed. Reg. 56056 (1983). The review must take the form of "an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review." 42 C.F.R. § 447.253(c) (1988). Thus, state administrative review must be both comprehensive and quick.

Medicaid regulations require only that the state Medicaid agency provide an appeals procedure "with respect to such issues as the [state] agency determines appropriate." 42 C.F.R. § 447.253(c) (1988). This regulation was promulgated pursuant to Congress's directive that HCFA develop alternative rate dispute resolution mechanisms so that providers would not be totally barred by existing law (apparently a reference to the Eleventh Amendment) from disputing reimbursement rates. S. Rep. No. 1240, 94th Cong., 2d Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. Through an executive agency and directly (in 42 U.S.C. § 1396a(a)(37)(B)), Congress left the decision as to the particulars of each State's appeals system to the State. As HCFA recognized, this decision permits each State to tailor its appeals system to its particular reimbursement system so as best to effectuate that system and secure whatever rights (if any) it confers:

> [T]he States, not the Federal government, are in the best position to determine the administrative process that would best meet their needs and be most compatible with their reimbursement system. . . . States are free to establish reasonable criteria for appeals to limit the issues on appeal that may be appropriate . . . .

48 Fed. Reg. 56052 (1983).

Virginia has adopted an appeals system that it has found to be compatible with its reimbursement system and that gives providers reasonable and sufficient opportunities to challenge reimbursement decisions. Under this system, which HCFA has found to be fully satisfactory, health care providers and facility patients may contest DMAS reimbursement and benefit decisions through three levels of administrative review (informal conference, formal hearing, and agency head decision). At each level providers, with the assistance of counsel, may present pertinent facts and evidence. Va. Code Ann. § 9-6.14:11 *et seq.* (1989).[17] If dissatisfied with the decision received at the end of the administrative review, providers or patients may obtain judicial review in three levels of state courts under the Virginia Administrative Process Act. Va. Code Ann. § 9-6.14:1 *et seq.* (1989). Thus, administrative and judicial review of both state benefit and reimbursement decisions were available to respondent as a matter of right.

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[17] For example, the hospital can present evidence that its costs are generated by factors not shared by other hospitals in its peer group and that it has taken reasonable action to contain its hospital-wide costs. The hospital can challenge the hearing officer's use of operating and financial ratios and related standards of efficiency, subject only to Virginia's flexible administrative rules. Finally, the hospital can attempt to show that adherence to its current reimbursement rate jeopardizes its long-term financial viability and that the population served by the hospital has no reasonable access to other inpatient hospitals. See *State Plan Under Title XIX of the Social Security Act*, Exhibit 1 of Respondent's Amended Complaint, J.A. 36-41.

Despite Congress's requirement that each State establish an appeals system that best serves its particular reimbursement system, and despite Virginia's compliance with that mandate, respondent alleges (¶ 32 of the Amended Complaint, J.A. 18-20), that Virginia's appeals system is not "meaningful" because, *inter alia*, it makes certain issues (*e.g.*, the establishment of peer groups and the inflation index used) non-appealable. Under *Sea Clammers*, 453 U.S. at 20, however, a remedial scheme can be "sufficiently comprehensive" even if it does not allow for plenary review of all conceivable statutory violations or, what may amount to the same thing, even if it does not allow review and remedies that are as extensive as those provided for in Section 1983. In a related context, this Court held in *Great American Federal Savings & Loan Ass'n v. Novotny*, 442 U.S. at 373-76, that remedies under Title VII of the 1964 Civil Rights Act were sufficient to bar the plaintiff's 42 U.S.C. § 1985(3) remedy even though the Title VII remedies were significantly narrower than those of Section 1985(3).[18] In short, the criterion of sufficiency under *Sea Clammers* is not whether the remedial mechanisms of the statute are as broad as they conceivably could be or as broad as those of some other statute (*e.g.*, Section 1983); rather, the test is whether the remedial mechanisms mandated by the statute effectively secure the substantive rights conferred by that statute. Virginia's appeals system in and of itself, and certainly in combination with federal oversight mechanisms, satisfies this test.

The corollary to the "sufficiently comprehensive" test, namely, whether a Section 1983 remedy would impair the effectiveness of the Medicaid Act, also shows Virginia's appeals system to be sufficiently comprehensive. Permitting a Section 1983 action would impair the ef-

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[18] See also *Hervey v. City of Little Rock*, 787 F.2d 1223, 1233 (8th Cir. 1986) (applying *Novotny* to find statutory foreclosure of a Section 1983 suit); *Irby v. Sullivan*, 737 F.2d 1418, 1428-29 (5th Cir. 1984) (same).

fectiveness of Virginia's and other States' reimbursement and appeals systems by moving the forum for rate reimbursement challenges from the States, where they belong, to the federal courthouse, where they do not. Medicaid reimbursement decisions, based as they are on extensive technical data, simply are not conducive to efficient review by federal courts.[19] By contrast, administrative appeals procedures tailored to local conditions are designed to make precisely the sort of prompt, highly factual determinations inherent in rate reimbursement review. Thus it is reasonable to conclude that when Congress established vague standards for lawful conduct such as "reasonableness" and "adequacy" and also mandated administrative mechanisms to interpret and apply the standards, Congress intended to foreclose a Section 1983 remedy.[20]

The right urged by respondents and accepted by the court below must be seen for what it is: a license to contest in federal court under Section 1983 every reimbursement term in a provider contract and every reimburse-

[19] *Maine v. Thiboutot*, 448 U.S. 1 (1980), stands in sharp contrast. In that case, the issue was whether, in computing Aid to Families with Dependent Children benefits (to which a father was entitled for his three children by a previous marriage), allowance should be made for money spent to support his five children by a current marriage. The claim was based on specific provisions of the federal statute and was a purely legal dispute, not requiring the technical, factual expertise demanded by Medicaid rate reimbursement challenges. Moreover, the claimant had pursued the State's administrative remedies and judicial review procedures.

[20] See Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. Chi. L. Rev. 394, 414, 428-29 (1982); see also *Local 1325, Retail Clerks Int'l Ass'n v. NLRB*, 414 F.2d 1194, 1199-1200 (D.C. Cir. 1969) (vagueness of statutory standard indicates that Congress intended to give NLRB responsibility to define what collective bargaining units are "appropriate"); cf. *National Railroad Passenger Corp. v. National Ass'n of Railroad Passengers*, 414 U.S. 453, 461-64 (1974) (private suits for injunctions against discontinuance of passenger rail service would undermine orderly administrative procedures prescribed by Amtrak Act).

ment rate decision made by a state Medicaid agency. If this license is granted, the sure guidance furnished to States, recipients, and providers by written state reimbursement plans will give way to the vagaries of case-by-case adjudication. The federal courts will become glorified Medicaid claims adjusters, reviewing countless highly technical, individual reimbursement decisions. The state reimbursement systems, rather than being central to the Medicaid program, will be reduced to nothing more than one piece of evidence used by litigants and the courts in contests over the reasonableness and adequacy of the States' reimbursement rates. Moreover, a decision of this Court authorizing dissatisfied providers to proceed directly into federal court would render the state administrative appeals procedures superfluous and the congressional mandate for them (42 U.S.C. § 1396a (a)(37)(B)) meaningless. See *Smith v. Robinson*, 468 U.S. at 1012 (precluding Section 1983 action for violation of the Education of the Handicapped Act in part because such a result would render provisions in the statute superfluous).

In sum, this Court has refused to assume that Congress intended to condition federal funds upon the States' incurring "largely indeterminate"[21] obligations such as providing "reasonable and adequate" reimbursement rates. This principle has special applicability where, as here, Congress has mandated the type and scope of remedy that the States must provide for rate reimbursement challenges, and States, including Virginia, have expended funds to meet this requirement. See *Tennessee Valley Authority v. Hill*, 437 U.S. 153, 188 (1978) (applying maxim of *expressio unius est exclusio allerius*). Because imposing a Section 1983 remedy on the sufficiently comprehensive and congressionally mandated state remedies would impair the effectiveness of such remedies, this

[21] *Pennhurst I*, 451 U.S. at 24-25 (using this phrase to describe the terms "appropriate treatment" and "least restrictive" setting).

Court should hold that respondent has no right of action under Section 1983 against Virginia.

Obviously, respondent, like the plaintiffs in *Smith v. Robinson* and *Sea Clammers*, would prefer to bring a Section 1983 action to remedy alleged violations of a federal statute and regulations rather than to seek relief through the review procedures required by the federal statute. The determinative inquiry, however, is not the wish of the plaintiff but the intention of Congress. See *Smith v. Robinson*, 468 U.S. at 1012 ("The crucial consideration is what Congress intended."). Virginia's federally mandated appeals system, together with the existing federal oversight of its state plan, is sufficiently comprehensive to evince a congressional intent to secure whatever rights are granted by the Medicaid Act through these remedial devices and to foreclose a Section 1983 remedy.

D. If Adopted By This Court, Respondent's Position Would Have Profoundly Adverse Consequences For Federal-State Relations And The Federal Courts' Caseload.

Respondent contends that, notwithstanding the provisions of the contract that it signed with DMAS, it is entitled to more money from Virginia because Virginia's rates are not "reasonable and adequate." Respondent's position is sufficient to ground a Section 1983 action only if this Court effectively rewrites the Medicaid Act, making the state plans, so carefully conceived as the linchpins of the Medicaid system, almost irrelevant. Several consequences would follow from such action by the Court. Most important, nearly every federal-state "'cooperative program of shared responsibilit[ies] [will become] a device for the Federal Government to compel . . . State[s] to provide services that Congress itself is unwilling to fund.'" *Pennhurst I*, 451 U.S. at 22, citing *Harris v. McRae*, 448 U.S. at 309 (describing the Medicaid program). But Congress did not intend "cooperative federalism"[22] to become federal co-option of the States' sovereignty.

If the judgment below is affirmed, it is readily foreseeable that a large number of providers dissatisfied with reimbursement rates will follow the path of the VHA to the perceived haven of the federal district court—particularly with the vision of 42 U.S.C. § 1988 attorney's fees ahead. The resulting burden on limited state resources and crowded federal dockets would be further compounded because rate reimbursement decisions are not one-time events. The current number of such cases, itself impressive, would be just the beginning.[23] These cases,

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[22] *Harris v. McRae*, 448 U.S. at 308 (quoting *King v. Smith*, 392 U.S. at 316).

[23] In addition to this case, there are at least twenty-three pending cases challenging state reimbursement rates or appeals systems under Section 1983. These cases are listed in Appendix B of the amicus brief submitted by thirty-seven States in support of Virginia's petition for certiorari. Two of the cases cited in Appendix B as pending have now been decided: *West Virginia Hosps., Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989); *Amisub (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989). In addition to these two cases, at least twelve other identical or similar cases have also already been decided: *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988); *Coos Bay Care Center v. Oregon Dep't of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 481 U.S. 1036, vacated as moot, 484 U.S. 806 (1987); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987); *United Hosp. Center, Inc. v. Richardson*, 757 F.2d 1445 (4th Cir. 1985); *Agi-Bluff Manor, Inc. v. Reagen*, 713 F. Supp. 1535 (W.D. Mo. 1989); *Vantage Healthcare Corp. v. Virginia Bd. of Medical Assistance Servs.*, 684 F. Supp. 1329 (E.D. Va. 1988); *St. Tammany Parish Hosp. Serv. Dist. v. Department of Health and Human Resources*, 677 F. Supp. 455 (E.D. La. 1988); *Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985); *Al-Charles, Inc. v. Heintz*, 620 F. Supp 327 (D. Conn. 1985); *Arden House, Inc. v. Heintz*, 612 F. Supp. 81 (D. Conn. 1985); *Yapalater v. Bates*, 494 F. Supp. 1349 (S.D.N.Y. 1980), aff'd per curiam, 644 F.2d 131 (2d Cir. 1981), cert. denied, 455 U.S. 908 (1982); *Bethany Medical Center v. Harder*, 1987 WL 47845 (D. Ks. 1987).

moreover, will not be limited to Medicaid disputes. Numerous federal-state cooperative endeavors provide federal funds to the States for programs that are contained in state plans approved by a federal agency.[24] Federal courts would be inundated with Section 1983 claims brought by businesses and individuals participating in federally funded programs with complaints about the States' implementation of their own regulations.[25]

The policy rationale for preventing respondents from bypassing state procedural structures flows from the system of "cooperative federalism" of which Medicaid is a part. See *Harris v. McRae*, 448 U.S. at 308. Pursuant to 42 U.S.C. § 1396a(a)(37)(B), Congress placed the responsibility for reviewing reimbursement decisions upon the States because they are best able to determine a schedule of rates. Through the technical expertise of administrative tribunals and their knowledge of local conditions and concerns, States are particularly suited to provide the type of fast, efficient review that serves the interests of providers as well as state Medicaid agencies.[26]

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[24] See, *e.g.*, 16 U.S.C. § 460*l*-8(d) (Land and Water Conservation Fund program); 20 U.S.C. § 1205 (Adult Education program); 20 U.S.C. § 1413 (Education of the Handicapped program); 42 U.S.C. § 654 (Child Support Enforcement program). See *Maine v. Thiboutot*, 448 U.S. at 34-37 (Powell, J., dissenting) (appendix) for a more complete list of such programs.

[25] Thus, in addition to its deficiencies in stating a cause of action under Section 1983, respondent's complaint raises serious Eleventh Amendment questions. See *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89 (1984) (*"Pennhurst II"*).

[26] In the closely related context of Medicare reimbursement, this Court held that, in light of Congress's intent that administrative procedures be used, the dissatisfied program participants before the Court had to avail themselves of their administrative remedies before proceeding into federal court. See *Heckler v. Ringer*, 466 U.S. 602 (1984). In deferring to Congress, the Court explained in words equally applicable to Medicaid reimbursement (*id.* at 627) (footnote omitted):

> Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be balanced against the potential for overly casual or premature judicial intervention in an administrative system that processes literally millions of claims every year. If the balance is to be struck anew, the decision must come from Congress and not from this Court.

Rate reimbursement disagreements may be more cheaply resolved at the state level before they become expensive Section 1983 lawsuits. Moreover, because the State-provider relationship is ongoing, interests of long-term stability require a less contentious forum than the adversarial arena of a federal district court. Finally, federal court litigation compounds the States' costs, for the States would remain obligated to fund the administrative review process. In short, authorization of Section 1983 actions would produce a costly, duplicative system of dispute resolution.

This result cannot be permitted in light of the language of the Boren Amendment, its legislative history, and the relevant agency interpretation, all of which demonstrate that the Medicaid Act does not confer on providers any substantive right secured by federal law.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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